

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03678

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Faulkner				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlotte Hall			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. #1 Box 112				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Juris B Berts				4. DATE OF DEATH Month Day Year 3-19-66 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-1904	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber mill		11. BIRTHPLACE (State or foreign country) Riga Latvia		12. CITIZEN OF WHAT Latvia	
13. FATHER'S NAME Juris B Berts				14. MOTHER'S MAIDEN NAME Emma Paeglis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 579-42-6878			
17. INFORMANT Wife-Melda A. Berts				Address Rt. #1 Box 112 Charlotte Hall			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries Multiple Extreme 9/25 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Bull-dozer turning over on him (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was crushed by having a bull-dozer turn over on him			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1-PM 3-19-66				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Main Road	
20f. (City or town) (County) (State) Faulkner, Charles Md							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James E. Andrews MD				22. DATE SIGNED 3-19-66			
EXAMINER'S NAME (Type) James E. Andrews MD				Address (Street, city, town, or county) Indian Head Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/66		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR The S. H. Hines Co.				ADDRESS Washington, D.C.		25a. REC'D BY REGISTRAR DATE MAR 23 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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The S. A. Jones Co. Washington, D. C. MAR 2 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03689  
03679  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Catherine Diggs		4. DATE OF DEATH Month Day Year March 11 1966		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/22/1899	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Charles County, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME (Unknown) Marshall		14. MOTHER'S MAIDEN NAME (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Blanche Tolson-Sister-in-law	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1980 DUE TO (b) of glands of neck, source DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5-5-65		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 5-5-65, to 3-11-66, that (I) (we) last saw the deceased alive on 3-9-66, and that death occurred at 4 M, from the causes and on the date stated above.					
22a. SIGNATURE E. J. Edelen				22b. DATE SIGNED 3-11-66	
22c. PHYSICIAN'S NAME (Type) E. J. EDELEN				22d. ADDRESS La Plata Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/14/1966		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Manor Cemetery - Bel Alton, Maryland	
23d. LOCATION (City, town or county)		(State)		25a. REC'D BY REGISTRAR MAR 15 1966	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. - La Plata, Md.		ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

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0380

Bel Alton

Bel Alton

18 89

Charles County, Md. U.S.A.

At home

House wife

(Unknown) Marshall

(Unknown)

Bel Alton

Mr. Blanche Tolson - 1911-1912

Unknown

Mo

Funeral Home, Inc. - 1414 1/2 St. N.W. Washington, D.C. 20004  
Funeral Home, Inc. - 1414 1/2 St. N.W. Washington, D.C. 20004

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FOR STATE HEALTH DEPT.

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03690 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03680

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata</b>				c. LENGTH OF STAY IN 1b <b>Waldorf</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>				d. STREET ADDRESS <b>Waldorf</b>			
3. NAME OF DECEASED (Type or print) <b>JAMES O. HAMILTON</b>				4. DATE OF DEATH Month <b>3</b> Day <b>21</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-24-01</b>	9. AGE (In years last birthday) <b>65</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>21</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TOBACCO</b>		11. BIRTHPLACE (State or foreign country) <b>Waldorf, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>John D Hamilton</b>			
14. MOTHER'S MAIDEN NAME <b>LAURA VERNON</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>4221</b>				17. INFORMANT <b>Ida Hamilton</b> Address <b>Waldorf, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4221</b> (c) <b>DUE TO</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>RUSSELL S. FISHER, M.D.</b>				22. DATE SIGNED <b>3-21-66</b>			
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-24-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's</b>		23d. LOCATION (City, town or county) (State) <b>Waldorf Md.</b>	
24. FUNERAL DIRECTOR <b>HUNT FUNERAL HOME</b>				ADDRESS <b>Waldorf, Md</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03692

03681

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Charles</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>La Plata</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Physicians Memorial Hosp.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Charles</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Port Tobacco</b> d. STREET ADDRESS <b>08-1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>ALBERT Augustine</b> <span style="float: right;">First Middle Last</span>		<b>4. DATE OF DEATH</b> Month <b>3</b> Day <b>19</b> Year <b>1966</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Cauc</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 8, 1915</b>		<b>9. AGE</b> (In years last birthday) <b>50</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Printer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Printing</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Charles County, Md.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Louis Metcalf Hyde</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth G. Burch</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>Unkown</b>		<b>17. INFORMANT</b> <b>Mrs. Laura M. Hyde</b> , <b>Port Tobacco, Md.</b> <span style="float: right;">Address</span>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from 3-15-66 to 3-19-66, that (I) (we) last saw the deceased alive on 3-19-66, and that death occurred at 9 A.M., from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> 						<b>22b. DATE SIGNED</b> <b>3/20/1966</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>E. J. EDELEN M.D.</b>					
<b>22d. ADDRESS</b> <b>La Plata, Md.</b>						<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>3-23-66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Ignatius Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Chapel Point, Md.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Archart Funeral Home, Inc., La Plata, Md.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>MAR 28 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 					

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03592

## CERTIFICATE OF DEATH

Item 9 Film G375 4/1/66 mh

03682

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> c. LENGTH OF STAY IN b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Physicians Memorial Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Charles</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Morgantown</u> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>FRANK</u> <sup>First</sup> <u>THOMAS</u> <sup>Middle</sup> <u>Jones</u> <sup>Last</sup>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>22</u> Year <u>1966</u>		<b>5. SEX</b> <u>Male</u>			
<b>6. COLOR OR RACE</b> <u>Cauc.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>10-5-1880</u>		<b>9. AGE (In years last birthday)</b> <u>86</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Charles County, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>William C. Jones</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Batiman</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>210418-6726</u> <b>17. INFORMANT</b> <u>James D. Jones, Box 37, Newburg, Md.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u> <u>Anemia</u>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>3-21-66</u> to <u>3-22-66</u> , that (I) (we) last saw the deceased alive on <u>3-21-66</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>E. J. Edele</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3/23/66</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>E. J. EDELEN</u> <b>M.D.</b>		<b>22d. ADDRESS</b> <u>La Plata, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-25-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Christ Church Cemetery</u>			
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Archart Funeral Home, Inc., La Plata, Md.</u>		<b>ADDRESS</b> <u>La Plata, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 28 1966</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9250

2007/05/10

[illegible][illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 1 Film G375 4/4/66									
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03693 CERTIFICATE OF DEATH 03683									
1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - CHARLOTTE HALL</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - CHARLOTTE HALL</b> <b>18-2</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Home of Grand Daughter</b>					d. STREET ADDRESS <b>18-2</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>HENRY</b> Last <b>KEYS</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>23</b> Year <b>1966</b>						
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/12/1876</b>		9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>BENJAMIN KEYS</b>					14. MOTHER'S MAIDEN NAME <b>ELIZABETH SHIRLEY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MRS. LUCY SPEAKS</b> <b>BALTIMORE, MARYLAND</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>4221</b> DUE TO <b>ASCUD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>JANUARY, 1966</b> , to <b>3/23/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/21/66</b> 19 <b>66</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Leon W. Berube</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <b>LEON W. BERUBE M.D.</b>			22b. DATE SIGNED <b>3/23/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEON W. BERUBE M.D.</b>					22d. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>3/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPHS CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>MORGANZA, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>P. B. ROBINSON - LEONARDTOWN, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03694

03684

1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>La Plata</b> c. LENGTH OF STAY IN 1b <b>La Plata</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Physicians &amp; Surgeons Memorial Hosp't</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier, Md.</b> d. STREET ADDRESS <b>4013 20, street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Neil</b> Middle <b>Robison</b> Last <b>Mc Callum</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb 20, 1910</b>
9. AGE (in years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. BIRTHPLACE (State or foreign country) <b>North Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>David G Mc Callum</b>		14. MOTHER'S MAIDEN NAME <b>Delia Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1927-1931</b>	
17. INFORMANT <b>Delia Mc Callum</b>		Address <b>Mt Rainier, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Massive</b> <b>578X</b> DUE TO (b) <b>Massive Internal (G.I.) Bleeding</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward T. Edelen</b> EXAMINER'S NAME (Type) <b>Edward T Edelen</b>		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 9, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch s Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 10 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-10-68

3000

1. The first part of the report is a description of the project and its objectives. It is followed by a brief history of the project and a list of the people who have been involved in it.

2. The second part of the report is a description of the methods used in the project. It includes a list of the equipment used and a description of the procedures followed.

3. The third part of the report is a description of the results of the project. It includes a list of the data collected and a description of the analysis of the data.

4. The fourth part of the report is a discussion of the results of the project. It includes a list of the conclusions drawn from the results and a list of the recommendations for future work.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03695					03685				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <b>Charles</b>					a. STATE <b>Md.</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pisgah</b>					b. COUNTY <b>Charles</b>				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pisgah</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last <b>Margaret Ellen Ann Medley</b>					Month Day Year <b>March 29 19 66</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>Cau.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-17-1880</b>		9. AGE (In years last birthday) <b>85</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pisgah, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <b>Joseph W. Lyon</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Ann Maddox</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mr. Joseph Medley Clinton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>4201</b> DUE TO <b>Coronary Thrombosis with Acute Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Acute Respiratory Infection</b>				INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-1-66</b> to <b>3-29-66</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>3-28-66</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Frank A. Susan</b>				22b. DATE <b>3-29-66</b>				22c. PHYSICIAN'S NAME (Type) <b>Frank A. Susan</b>	
22d. ADDRESS <b>Indian Head, Md.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-1-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Charles</b>		23d. LOCATION (City, town or county) (State) <b>Indian Head, Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home, Uddelof Md</b>									
25. REC'D BY REGISTRAR <b>APR 4 1966</b>									
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

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Domestic

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Ellie Ann Maffox

Joseph, John

7233 1st Street

St.

Mr. Joseph Maffox, Living, Mr.

Chronic Bronchitis with Acute Complications 20 minutes  
Heart Failure

Acute Respiratory Infection

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Indian Head, Mr.

Frank A. Smith

Indian Head, Mr.

St. Charles

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

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03696

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03686

1. PLACE OF DEATH a. COUNTY <b>Charles</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>				d. STREET ADDRESS <b>La Plata, Md.</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Cleveland</b> Last <b>Montgomery</b>				4. DATE OF DEATH Month <b>3</b> Day <b>4</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cal.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-19-1884</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>08</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>66</b>		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MD. TOB. GROWERS</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Charles Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>			
13. FATHER'S NAME <b>James Montgomery</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Wilkerson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-07-9865</b>			
17. INFORMANT <b>Mrs. Mary G. Montgomery</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Aggravated Rec</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>New Rec Rec</b> (c) <b>11-53</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Concussion Failure 3-7-66</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-3-65</b> to <b>2-4-66</b> that (I) (we) last saw the deceased alive on <b>2-18-66</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>E. J. Edelen</b>				22b. DATE SIGNED <b>3-4-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. J. EDELEN</b>				22d. ADDRESS <b>LA PLATA, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-7-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Waldorf, Md.</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>HUNT FUNERAL HOME, WALDORF, MD.</b>				25a. REC'D BY REGISTRAR <b>10 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

MEDICAL CERTIFICATION

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03687

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b> c. LENGTH OF STAY IN 1b <b>101 Indian Head Avenue</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>101 Indian Head Avenue</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b> d. STREET ADDRESS <b>101-Indian Head Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert Howard Murdock</b> First Middle Last 4. DATE OF DEATH <b>3-22-66</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>W-US</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>4-6-1886</b> 9. AGE (In years lost birthday) yrs. <b>79</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) <b>Retired-US Govt.</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Propellant Plant</b> 11. BIRTHPLACE (State or foreign country) <b>Nanjemoy Md</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert A. Murdock</b> 14. MOTHER'S MAIDEN NAME <b>Jane M. Henderson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None</b> 16. SOCIAL SECURITY NO. <b>218034-6402</b> 17. INFORMANT <b>Daughter</b> Address <b>Margeret Gray-Indian Head Md</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Malnutrition</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma General</b> DUE TO (c) <b>Carcinoma of the Prostate</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While <input type="checkbox"/> Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 22. DATE SIGNED <b>3-23-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>3-25-66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Old Durham</b> 23d. LOCATION (City or Town) (County) (State) <b>Ironsides, Charles, Md.</b>		24. FUNERAL DIRECTOR <b>Archart Funeral Home, Inc., La Plata, Md.</b> 25a. REC'D BY REGISTRAR <b>MAR 28 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

582



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

03698

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03688

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HUGHESVILLE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hughesville</b> d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ETHEL ELIZABETH PLATER</b>				4. DATE OF DEATH Month Day Year <b>3 14 19 66</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 8/1912</b>		9. AGE (In years last birthday) <b>53 yrs.</b>		IF UNDER 1 YEAR Months Days <b>19 66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>St. Mary's Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Hawkins</b>				14. MOTHER'S MAIDEN NAME <b>Mary Mark</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>George Plater Hughesville, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of liver</b> <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Russell S. Fisher</b>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>3-14-66</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3-17-66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Ch. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Bryantown, Md.</b>		(State)	
23. FUNERAL DIRECTOR <b>Martell Adams</b>						ADDRESS <b>Aguasco, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 21 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at in any event, within 72 hours after death.

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Page 2 of 2

1994-1995-1996

1M  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03690

1. PLACE OF DEATH a. COUNTY <b>Charles</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b <b>MARYLAND</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>#1 Edgewood Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Physicians Memorial Hospital</b>				d. STREET ADDRESS <b>Bryans Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John N. Ritch, Sr.</b>				4. DATE OF DEATH Month <b>3</b> Day <b>10</b> Year <b>1966</b>							
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 9, 1912</b>		9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co.</b>				11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 11 578-0390765</b>		17. INFORMANT <b>Elva M. Ritch</b>		Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemopericardium</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dissecting aneurysm of arch of aorta</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Werner U. Spitz</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>3/11/66</b>			
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/15/66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) <b>Fort Myer</b>		(State) <b>Virginia</b>			
23. FUNERAL DIRECTOR <b>J. Wm. Lees Sons</b>						ADDRESS <b>300 4th St. NE Wash., DC</b>		24a. REC'D BY REGISTRAR <b>MAR 15 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Charles</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Doncaster (Rural)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Physicans Memorial Hospital</b>				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>NELLIE MAE SAUNDERS</b>				4. DATE OF DEATH Month <b>3</b> Day <b>12</b> Year <b>1966</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 12, 1892</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Duvall</b>				14. MOTHER'S MAIDEN NAME <b>Laura Bailey</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Dorotyh Maddox -Daughter</b>		Address <b>La Plata, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONG. HEART FAILURE</b> <b>442X</b> DUE TO <b>CARDIO VASCULAR RENAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DISEASE</b> DUE TO (c) <b>DISEASE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3-9-66</b> <b>?</b> <b>1</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I(a) <b>DIABETES MELLITUS</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-9-66</b> , 19 <b>66</b> , to <b>3-11-66</b> , 19 <b>66</b> ; that (I) (we) last saw the deceased alive on <b>3-11-66</b> , 19 <b>66</b> , and that death occurred at <b>3-11-66</b> , 19 <b>66</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>E. J. Edelen</b>				22b. DATE SIGNED <b>3/12/1966</b>							
22c. PHYSICIAN'S NAME (Type) <b>E. J. Edelen, M.D.</b>				22d. ADDRESS <b>La Plata, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>3/15/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Remington Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Remington, Virginia</b>			
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc.-La Plata, Md.</b>				25a. REC'D BY REGISTRAR <b>WAR 15 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Donnerstag (April)

July 12, 1892

Female White

U.S.A.

Virginia

at base

Housewife

Laura Bailey

Elizabeth Duvall

Mrs. Dorothy Barker - Engineer

Home

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END OF THE LINE  
A LIST OF THE

La Plata, Maryland

W. J. Stetson, M.D.

Hampton, Virginia

March 25, 1900

Home, Inc. - La Plata, Md.

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FOR STATE  
HEALTH DEPT. (C)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03692

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata</b> c. LENGTH OF STAY IN 1b <b>LaPlata</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata</b> d. STREET ADDRESS <b>08-1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DANA MARIE THOMPSON</b>		4. DATE OF DEATH Month Day Year <b>3 20 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-27-66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (State or foreign country) <b>La Plata, Maryland</b>
13. FATHER'S NAME <b>James Edward Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Veronica Makle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
15. INFORMANT <b>James E. Thompson, La Plata, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute interstitial pneumonitis</b> <b>492x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes XX</b> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		22. DATE SIGNED <b>3-21-66</b>	
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-24-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery La Plata, Maryland</b>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc., La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10-1-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03703 CERTIFICATE OF DEATH 05693

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>Mattawoman, Beantown, Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Genevieve</u> Middle <u>Mary</u> Last <u>Welch</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9 1888</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Pillar</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>John E. Welch, Waldorf, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>1992</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Anemia</u> DUE TO (c) <u>CARCINOMA Abdominal</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>Weeks</u> <u>Weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 19</u> , 19 <u>66</u> , to <u>MAY 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>MARCH 27</u> , 19 <u>66</u> , and that death occurred at <u>4:40</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas L. Fieldson</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>MAY 28, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas L. Fieldson</u>				22d. ADDRESS <u>Brandywine, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-30-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters</u>		23d. LOCATION (City, town or county) (State) <u>Waldorf, Md.</u>	
24. FUNERAL DIRECTOR <u>Hunt Funeral Home, Waldorf, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03704

03694

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) ISSUE</b>		c. LENGTH OF STAY IN 1b <b>lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>PERLEY</b> Last <b>Welch</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 18, 1882-84</b>
9. AGE (In years last birthday) <b>84</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (County & State, or foreign country) <b>St. Mary's Co., Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Edward Welch</b>	
14. MOTHER'S MAIDEN NAME <b>Mary L. Swann</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Thomas Welch-Son-Issue, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tumor in the parotid gland, Left.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>March 2, 1966</b> that (I) (we) last saw the deceased alive on <b>2 March 1966</b> , and that death occurred at <b>6 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Arthur O. Woody</b> M.D.		22b. DATE SIGNED <b>2 March 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>		22d. ADDRESS <b>LA PLATA, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/5/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Ghost Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Issue, Maryland</b>
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc.-La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03004

CERTIFICATE OF DEATH

03004

STATE OF NEW YORK  
COUNTY OF ALBANY

Form with multiple lines for text entry, including fields for name, date, and location. The form is oriented horizontally but contains vertical text labels for fields like 'Name', 'Date', and 'Place of Birth'.

Vertical text on the right margin, possibly a filing stamp or reference number, oriented vertically.